STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES
-

Assisted Housing Program

Change in Licensed Capacity Application

SECTION 1: Program Information			
Facility Name:		Legal Name (i.e. DBA):	
Mailing Address:			
City:	State:	Zip:	County:
Physical Address:			
City:	State:	Zip:	County:
Telephone No.: ( )		Fax No.: ( )	
Email Address:			

SECTION 2: Fees	
APPLICATION FOR ASSISTED HOUSING PROGRAM	
Select type of program: ☐ Check here if this is for a PNMI facility ☐ Residential Care Facility – Level I (fee $10 x number of additional requested beds: _____) ☐ Residential Care Facility – Level II (fee $10 x number of additional requested beds: _____) ☐ Residential Care Facility – Level III (fee $10 x number of additional requested beds: _____) ☐ Residential Care Facility – Level IV (fee $10 x number of additional requested beds: _____) ☐ Assisted Living – Type I (no fee) ☐ Assisted Living – Type II (no fee) **Total Fee Enclosed for licensed capacity ……**	$ _____
Make check or money order payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. **Total Check/Money Order enclosed =**	**$ _____**

For questions regarding this program and/or application, please contact the following:
Department of Health and Human Services
Licensing and Regulatory Services
Assisted Housing Program
41 Anthony Ave; 11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-9300 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: dlrs.info@maine.gov

Office Use Only:
Check# _____ *MO #* _____ *Amount $*_____ *Initials:* _____ *License#* _____

SBI _____ *Water* _____ *HFS* _____ *Ins.* _____ *SFMO* _____ *Multi-Level* _____

County _____ *Prog. Spec* _____

SECTION 3: Program Administrator/Applicant (to be completed by Administrator/Applicant)	
Legal Name:	Title:
Telephone No.: ( )	Fax No.: ( )
Email Address:	

1. Total number of licensed beds or units you currently manage: _____

2. Do you manage more than one (1) facility?

- ☐ No
- ☐ Yes, Please provide facility name(s) and nature of business: _____
  _____

3. Has your facility ever been placed on a Directed Plan of Correction or a Conditional License?

- ☐ No
- ☐ Yes, Please list when: _____

4. What changes in management of the facility will result with the change in the number of beds or units? _____

_____

_____

5. How do you plan to accommodate these changes? _____

_____

SECTION 4: Facility/Program Information

Capacity Change Information:

Current number of licensed beds: _____ Increase/Decrease in number: _____

Current resident census: _____ Do you have designated respite beds? ☐ No ☐ Yes, how many: _____

1. Type of rooms:
   - ☐ Existing
   - ☐ New construction, expected date of completion: _____
2. Number of additional rooms or units requested: _____
   - How many are singles: _____
   - How many are doubles: _____
   - Do any existing bedrooms have more than 2 beds? _____

   Assisted Living Only:
   - How many efficiency units: _____
   - How many 1 bedroom units: _____
   - How many 1+ bedroom units: _____
3. Type of heating system(s): _____
4. Is there direct heat into each room: ☐ No ☐ Yes
5. Are windows screened: ☐ No ☐ Yes
6. Does each bedroom have at least one window to the outside: ☐ No ☐ Yes
7. Are any new outside exits available from the building, including fire escapes? ☐ No ☐ Yes
8. Are these rooms currently furnished with required furniture? ☐ Yes ☐ No, expected date of completion: _____

SECTION 5: Submission

Submit your completed application, the following additional information and two copies of your application and additional information:

- A check or money order made payable to "Treasurer, State of Maine"
- A copy of the building permit or a letter signed by a town/city official stating that changes have been approved by local authorities
- A floor plan identifying the changed rooms in relation to the existing facility

Failure to submit the required information will delay the processing of your application.

NOTE: New construction, renovation, change of use, as well as other bed increases mandate approval from the State Fire Marshal. DLRS will notify these authorities of your pending request.

SECTION 6: Declaration

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

- I/We certify that all information provided herein is true and correct to the best of my knowledge.
- I/We certify that I am in compliance with all local laws and ordinances as they relate to zoning, plumbing, water supply, and sewage disposal.
- I/We understand that the signing of this application effectively serves as a release of information and gives permission to the Department to obtain criminal history and Bureau of Motor Vehicle records, which may be on file in any county or state office.

_____	_____	_____
Print name of Administrator/Applicant	**Signature of Administrator/Applicant**	**Date**
_____	_____	_____
Print name of Owner	**Signature of Owner**	**Date**